NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

MH/DD/SAS Community Systems Progress Indicators

Report for Second Quarter SFY 2006-2007

October 1 – December 31, 2006

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Quality
NC DMH/DD/SAS

*What we are witnessing today is a shift toward holding **human service systems** accountable for the benefits (or lack thereof) at the consumer level. …With [this] shift, measures have broadened and have begun to focus on consumer outcomes that are related to specific provider organizations and practitioners. Outcomes measures themselves are undergoing modification with less emphasis on diagnoses and symptoms and greater emphasis on recovery and resilience. The view of "the consumer" also is undergoing change with less emphasis on the individual and greater emphasis on the functional ecology of the individual (e.g. family, friends, neighborhood, community).*

…

Obviously, the transformation process calls for sustained leadership and will result in new roles in state systems and bureaucracies. Decision support data systems are essential to the entire process, so decisions can be made on the basis of better and better outcomes for children, families, and adults. Form will follow function. We cannot have new (better) outcomes by doing the same old thing. We need to go into the transformation process with clear purpose, a thoughtful approach, and excellent sources of data related to the overall mission and goals of the system being transformed. We need to expect and plan for organizational and system change. With practice, we can learn how to initiate and manage change effectively, we can learn how to implement innovations to achieve maximum benefits for consumers, and we can develop new services system infrastructures specifically designed to support excellence as practitioners work with consumers. With practice, our approach to transformation will be come well entrenched and the benefits to consumer will improve with each generation.

FromThe ImpleNet Quarterly e-Newsletter, National Implementation Research Network, Louis de la Parte Florida Mental Health Institute, University of South Florida. October 2006.

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Introduction

Effective management of community systems is essential for the success of North Carolina's efforts to transform its mental health/developmental disabilities/substance abuse service (MH/DD/SAS) system. Tracking the status and progress of community systems provides a means for the public and General Assembly to hold the Division of MH/DD/SAS and the Local Management Entities (LMEs) accountable for progress toward the goals of the system reform. Regular reporting of community progress also assists local and state managers in identifying areas of success and areas in need of attention. Problems caught early can be addressed more effectively. Success in a particular component of the service system by one community can be used as a model to guide development in other communities.

The following pages report local progress on key indicators of an effective and responsive service system, as defined by the goals of North Carolina's system transformation efforts and federal initiatives.[1] These indicators measure each local system's progress in three areas:

- Service Delivery
- Service Quality
- System Management

Within each of these areas, the Division has selected indicators to gauge problems and progress on reform goals. Each area covered by these indicators involves substantial "behind-the-scenes" activity by service providers, LME and state government staff, consumers, and family members. These indicators do not purport to cover all of those efforts. Instead, they provide critical highlights that can guide analysis by the public, the General Assembly, and local and state managers into more detailed issues that affect progress toward the goals of MH/DD/SAS system transformation. The indicators, along with the rationale for their use, are presented in Table 1 below.

Table 1: Rationale for Progress Indicators

Progress Area	Indicator	Rationale
Service Delivery	1. Services to Persons In Need (Treated Prevalence)[2]	NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance.

[1] This report begins to fulfill the requirements of House Bill 2077 that directs the Department of Health and Human Services to develop critical indicators of LME performance. Measures reflect the goals of the NC State Plans 2000-2006, the President's New Freedom Initiative, CMS' Quality Framework for Home and Community Based Services, and SAMHSA's Federal Action Agenda and National Outcome Measures.

[2] *Prevalence* is defined as the percent of the population estimated to have a particular condition within a given year. *Treated prevalence* is the percent of the population in need who receive services for that condition within a year.

Progress Area	Indicator	Rationale
	2. Timely initiation and engagement in service	Best Practice for initiating and continuing care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service).[3] These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.
	3. Effective use of state psychiatric hospitals	State psychiatric hospitals provide a safety net for the community service system. An adequate community system can and should provide their residents with crisis services and short-term inpatient care close to home. This helps families stay in touch and reserves high-cost state facility beds for consumers with long-term care needs. Reducing the short-term use of state psychiatric hospitals is a goal that also allows more effective and efficient use of funds for community services.
	4. Timely follow-up after inpatient care	Living successfully in one's community after discharge from a state-operated facility depends on smooth and timely transition to community supports. A community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and coordination across levels of care.[3]
Service Quality	5. Consumer choice of service providers	A system that offers consumers an array of providers supports the development of successful practitioner-consumer relationships which, in turn, foster recovery and stability. Consumer choice can also improve the quality of the entire service system, as providers strive to satisfy consumers.
	6. Use of evidence-based service models and best practices	Quality care is care that makes a real difference in an individual's life. Service models and practices that have been tested for effectiveness provide the greatest opportunity for individuals to attain stability in their lives. NC is promoting adoption of evidence-based practices in community service systems.
System Management	7. Involvement of consumers and family members in the local system	The vibrancy of the local Consumer and Family Advisory Committees (CFACs) provides an indication of the responsiveness of the local system and its effectiveness in meeting the needs of residents and consumers. An engaged CFAC membership, with balanced representation across disabilities, is necessary for the LME to hear and respond to the needs of its community.

[3] Health Plan Employer Data and Information Set (HEDIS®) measures.

Progress Area	Indicator	Rationale
	8. Effective management of service funds	Stretching limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.
	9. Effective management of information	Efficient flow of information is vital for effective decision making and oversight of a complex service system. Timely submission of consumer information is a gauge of the management and coordination capacity of the local system and the technological resources available to support it.

The information in this report complements the Quarterly DHHS-LME Performance Contract Reports, which evaluate each LME's compliance with 30 contractual items. *Indicator 4: Timely Follow-up Care after Inpatient Care* in the table above is replacing the measure previously used in the Performance Contract Reports. The data for *Indicator 9: Effective Management of Information* will continue to appear in both reports.

This second report includes data on those measures for which valid indicators and dependable data have previously been developed. These are addressed in Table 1 above. The report also includes placeholders for measures in development, which are addressed in Table 2 below.

Table 2: Indicators in Development

Progress Area	Indicator	Rationale
Service Delivery	1. Timely access to services	When an individual makes a request for service, quick response with the appropriate level of care is a gauge of the system's service capacity and coordination. National standards for access include providing care within two hours of request in emergency situations, within 48 hours in urgent situations, and within 7 days in non-urgent situations.[4]
Service Quality	2. Person-centered planning and delivery of services	Recovery and community stability hinge on designing services to meet the needs of each individual. A timely, comprehensive service plan developed collaboratively by a consumer and his or her providers with help from family, friends, and supporters is crucial to designing and delivering individualized services. Increasing the number of consumers with person-centered plans is a means to this end.
	3. Effective oversight of service quality	Local oversight of community services is essential for risk management and continuous improvement of the quality of care. LMEs' assessment of their providers' strengths and areas of need can guide technical assistance activities effectively. Increasing oversight to those providers with the greatest need for assistance improves the quality of the choices available to consumers.
System Development	4. Implementation of management functions	The success of a community service system depends on effective management. The LMEs have been charged with eight management areas: Governance and Administration, Business Management, Provider Relations, Customer Service & Consumer Affairs, Service Management, Quality Management, Claims Adjudication, and Screening, Triage & Referral (STR). Full implementation of these functions is critical for making progress toward the goals of NC's system transformation efforts.

Over the course of the current state fiscal year, the Division is working with a consultant to refine indicators and put in place mechanisms to track indicators in development. In addition, the Division will develop measures on:

- LME responsiveness to consumer complaints
- LME community collaboration activities

[4] Health Plan Employer Data and Information Set (HEDIS®) measures.

The following pages present graphs showing the progress of each LME on the nine selected indicators. For the Progress Area, Service Quality, LMEs are grouped according to their population density. The resulting categories – Urban, Mixed, and Rural – group LMEs that face similar challenges (e.g. transportation, number in need of intensive services).[5] Tables showing the statistics for each LME on the indicators are available in a separate document, the *Community Systems Progress Indicators Report Appendix*.[6] Both are available on the Division website at:

http://www.dhhs.state.nc.us/mhddsas/

[5] The data used to group LMEs into categories is available in Appendix B.

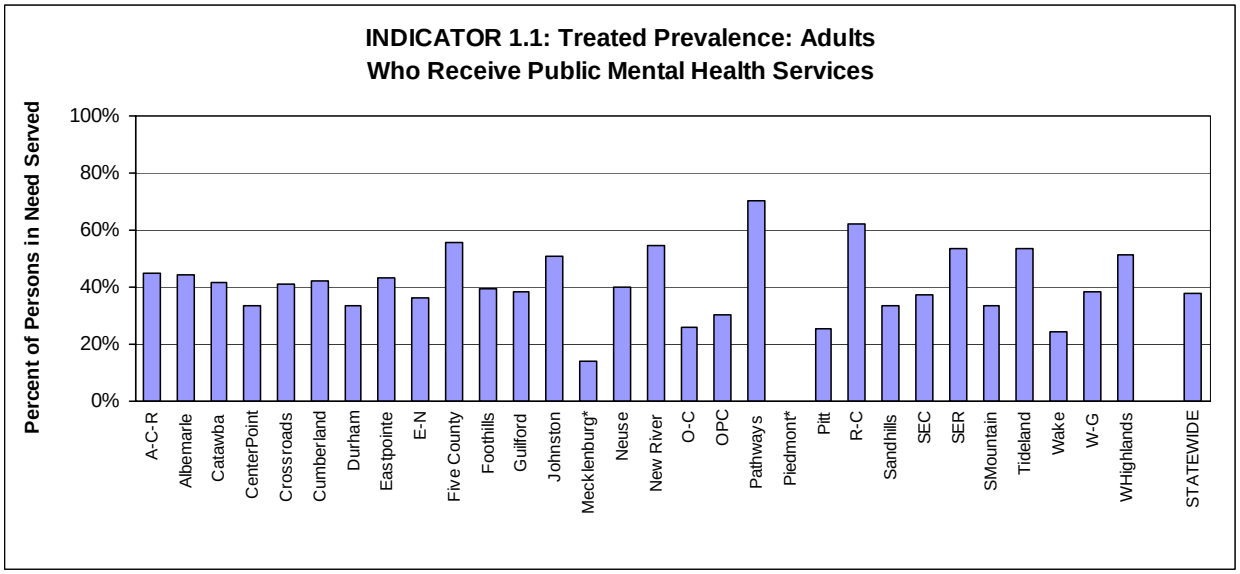
[6] A list of counties that make up each LME is available in the Report Appendix.

Service Delivery

Indicator 1: Services to Persons in Need

1.1 Adult Mental Health Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This indicator is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. October 1, 2005 - September 30, 2006; N=334,736 adults in need

Almost 55 out of every 1,000 adults (5.40%) in North Carolina experience a severe or severe and persistent mental illness (SMI or SPMI) in any given year.[7] Statewide, 126,803 adults (38% of those in need of services) received federal or state funded MH services through our community service system from October 2005 through September 2006.[8] The rate of adults who were served varied among LMEs from a low of 14% (Mecklenburg) to a high of 70% (Pathways).

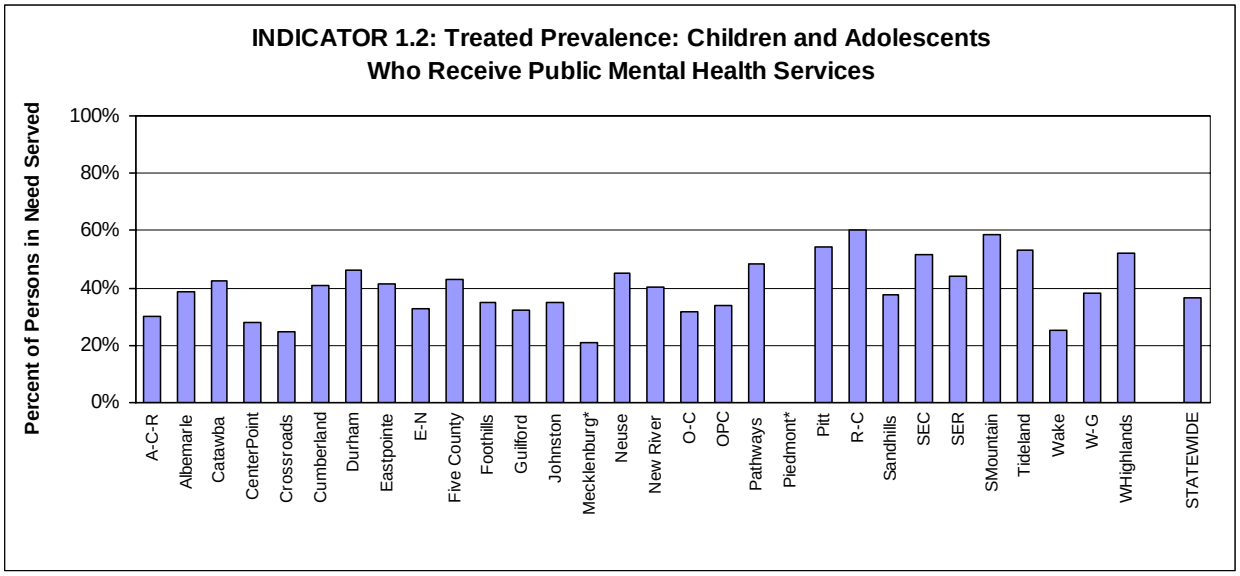
** Data on service claims for Piedmont are not available for this report. Mecklenburg's numbers may be underreported due to problems in their information management system.*

[7] URS Table 1: Number of Persons with Serious Mental Illness [*sic*], age 18 and older, by State, 2005, Midpoint of range between lower and upper limits of estimate. Prepared by NRI/SDICC for CMHS: August 29, 2006. Estimates adjusted to North Carolina population.

[8] The numbers served reflect adults, ages 18 and over, who received any MH services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private funds.

Indicator 1: Services to Persons in Need
1.2 Child and Adolescent Mental Health Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. October 1, 2005 - September 30, 2006; N=196,447 children and adolescents in need

In North Carolina, 120 out of every 1,000 children and adolescents (12.00%) experience severe emotional disturbances (SED) in any given year.[9] Statewide, 71,980 children and adolescents (37% of those in need of services) received federal or state funded MH services through our community service system from October 2005 through September 2006.[10] The rate of those served varied from a low of 21% (Mecklenburg) to a high of 60% (Roanoke-Chowan).

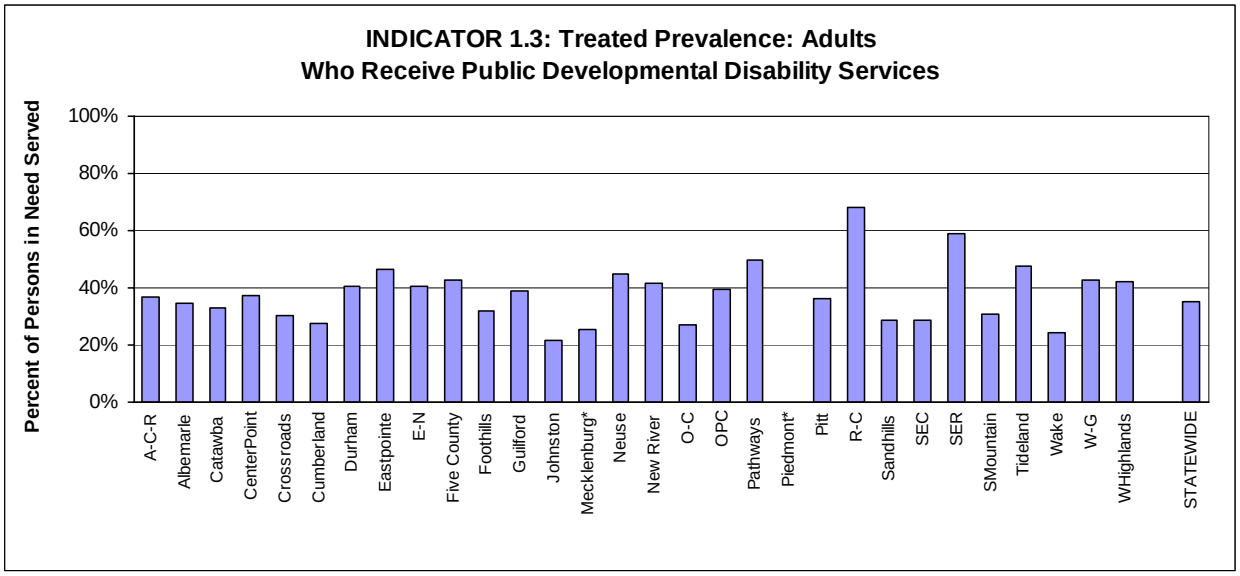
** Data on service claims for Piedmont are not available for this report. Mecklenburg's numbers may be underreported due to problems in their information management system.*

[9] URS Table 1: Number of Children with Serious Emotional Disturbances [*sic*], age 9 to 17, by State, 2005, Level of functioning score=60, midpoint of range between lower and upper limits of estimates. Prepared by NRI/SDICC for CMHS: August 29, 2006. Estimates adjusted to North Carolina population. Early childhood (ages 3-8) estimates from Glascoe and Shapiro, "Introduction to Developmental and Behavioral Screening." Reprinted from *Pediatric Development and Behavior Online* http://www.dbpeds.org. The Division applies the estimates established by CMHS for children ages 9-17 to those under the age of 9, since no established estimates exist.

[10] The numbers served reflect children and adolescents, ages 3-17, who received any MH services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private funds. The NC Division of Public Health is responsible for all services from birth through age 2.

Indicator 1: Services to Persons in Need
1.3 Adult Developmental Disability Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. October 1, 2005 - September 30, 2006; N=48,971 adults in need

Approximately eight out of every 1,000 adults (0.79%) in North Carolina have a developmental disability that requires supportive services.[11] Statewide, 17,308 adults (35% of those in need of services) received federal or state funded DD services through our community service system from October 2005 through September 2006.[12] The rate of adults who were served varied among LMEs from a low of 21% (Johnston) to a high of 66% (Roanoke-Chowan).

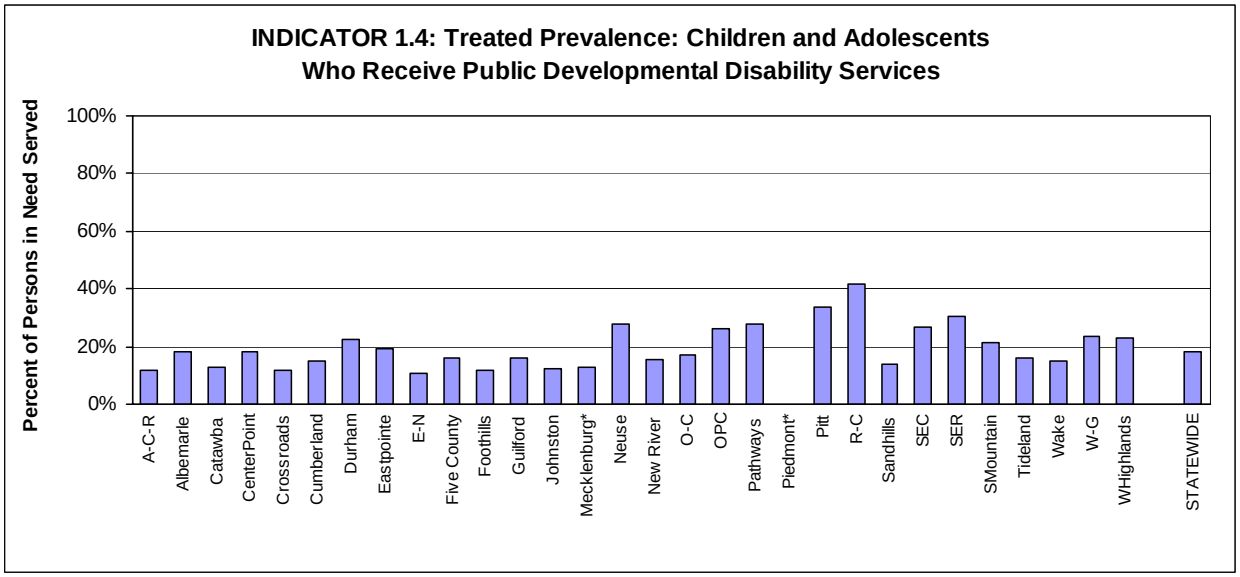
** Data on service claims for Piedmont are not available for this report. Mecklenburg's numbers may be underreported due to problems in their information management system.*

[11] Fact Sheet 2: Estimated Ages of People with MR/DD in US Non-Institutional Population from the 1994 and 1995 National Health Interview Survey (NHIS), http://rtc.umn.edu/docs/fs0102.html. Estimates adjusted to North Carolina population.

[12] The numbers served reflect adults, ages 18 and over, who received any DD services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private sources.

Indicator 1: Services to Persons in Need
1.4 Child and Adolescent Developmental Disability Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. October 1, 2005 - September 30, 2006; N=52,526 children and adolescents in need

Approximately thirty-two out of every 1,000 children and adolescents (3.21%) in North Carolina have a developmental disability that requires supportive services.[13] Statewide, 9,575 children and adolescents (18% of those in need of services) received federal or state funded DD services through our community service system from October 2005 through September 2006.[14] [15] The rate of those who were served varied among LMEs from a low of 11% (Edgecombe-Nash) to a high of 42% (Roanoke-Chowan).

** Data on service claims for Piedmont are not available for this report. Mecklenburg's numbers may be underreported due to problems in their information management system.*

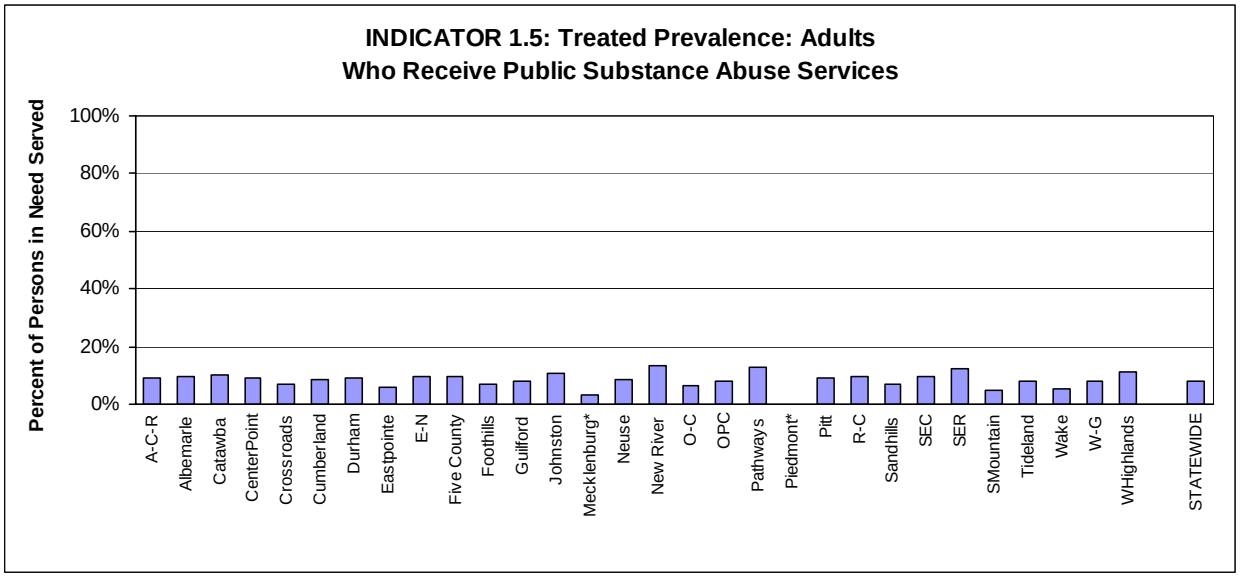
[13] Fact Sheet 2: Estimated Ages of People with MR/DD in US Non-Institutional Population from the 1994 and 1995 National Health Interview Survey (NHIS), http://rtc.umn.edu/docs/fs0102.html. Estimates adjusted to North Carolina population.

[14] The numbers reflect children and adolescents, ages 3-17, who received any DD services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private sources.

[15] The NC Division of Public Health is responsible for all services from birth through age 2. Local educational systems are responsible for educational services to children with developmental disabilities through age 21.

Indicator 1: Services to Persons in Need
1.5 Adult Substance Abuse Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. October 1, 2005 - September 30, 2006; N=494,665 adults in need

Almost eighty out of every 1,000 adults (7.98%) in North Carolina experience a serious substance abuse problem in any given year.[16] Statewide, 39,975 adults (8% of those in need of services) received federal or state funded SA services through our community service system from October 2005 through September 2006.[17] The rate of adults who were served varied among LMEs from a low of 3% (Mecklenburg) to a high of 13% (Pathways and New River).

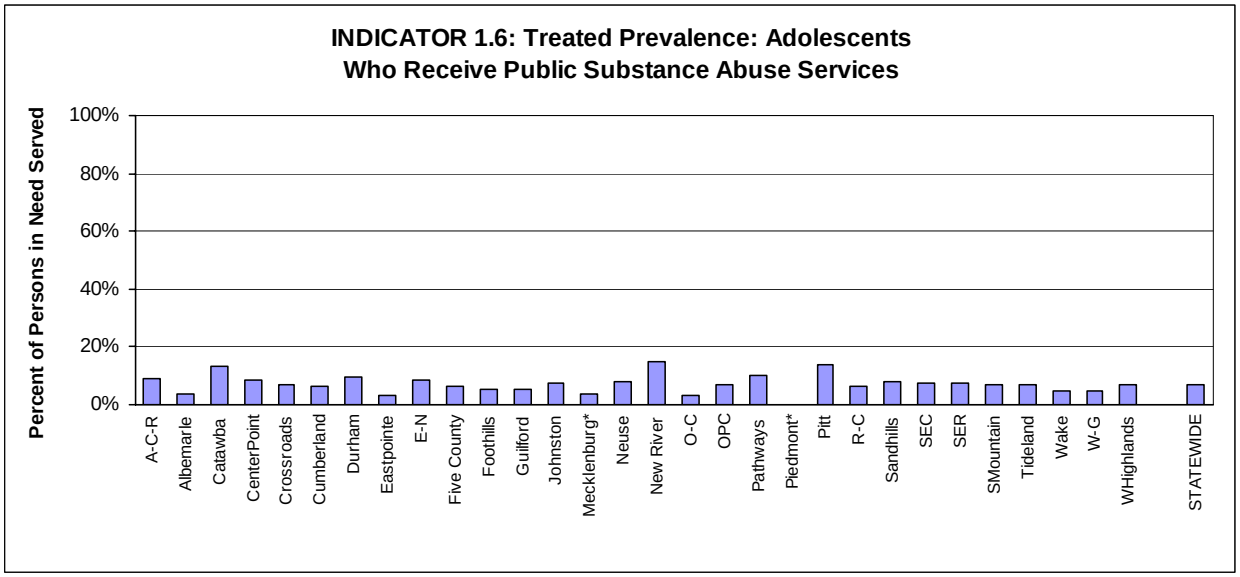
** Data on service claims for Piedmont are not available for this report. Mecklenburg's numbers may be underreported due to problems in their information management system.*

[16] *State Estimates of Substance Use from the 2003-2004 National Surveys on Drug Use and Health*, Table B.20, http://oas.samhsa.gov/nsduh.htm. Estimates adjusted to North Carolina population.

[17] The numbers served reflect adults, ages 18 and over, who received any SA services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private sources.

Indicator 1: Services to Persons in Need
1.6 Adolescent Substance Abuse Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. October 1, 2005 - September 30, 2006; N=47,673 adolescents in need

A little more than seventy out of every 1,000 adolescents (7.24% of those ages 12-17) in North Carolina experience a serious substance abuse problem in any given year.[18] Statewide, 3,219 adolescents (7% of those in need of services) received federal or state funded services through our community service system from October 2005 through September 2006.[19] The rate of targeted adolescents who were served varied among LMEs from a low of 3% (Eastpointe and Onslow-Carteret) to a high of 15% (New River).

** Data on service claims for Piedmont are not available for this report. Mecklenburg's numbers may be underreported due to problems in their information management system.*

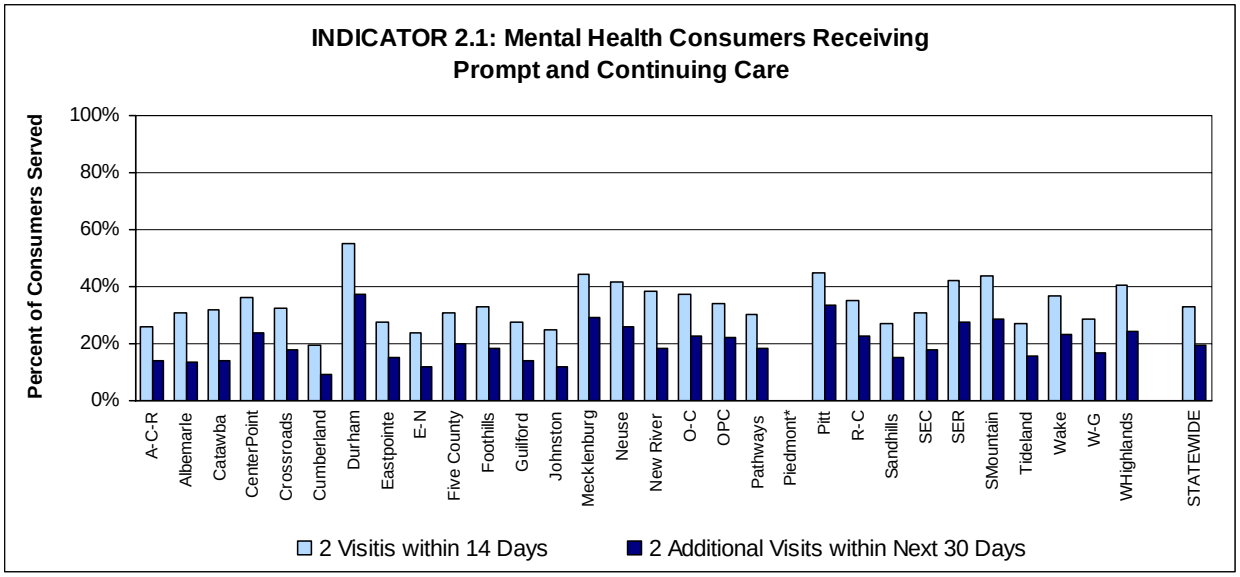
[18] *State Estimates of Substance Use from the 2003-2004 National Surveys on Drug Use and Health,* Table B.20, http://oas.samhsa.gov/nsduh.htm. Estimates adjusted to North Carolina population.

[19] The numbers served reflect adolescents, ages 12-17, who received any SA services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private sources.

Indicator 2: Timely Initiation and Engagement in Service

2.1 Mental Health Services

Rationale: Best practice for initiating and engaging consumers in care suggests that an individual receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. April 1 - June 30, 2006 (first service received); N=39,557 consumers

One-third of NC residents (all age groups) who receive mental health services have two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranges from a low of 19% (Cumberland) to a high of 55% (Durham). Compared to the other disability groups, consumers with mental illness wait longer on average for initiation of care.

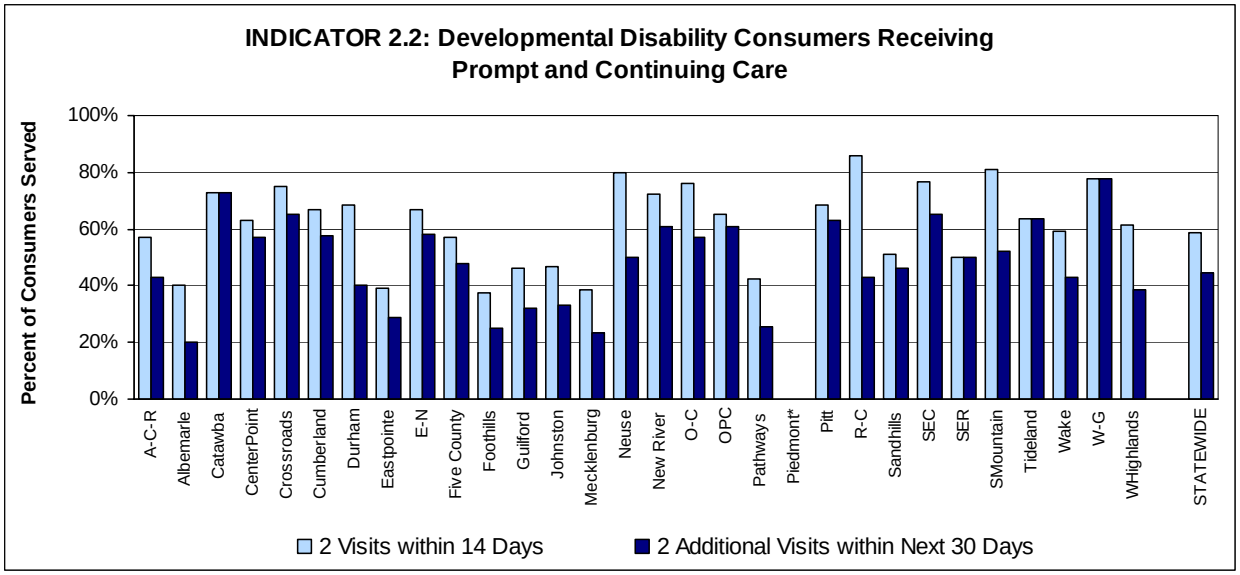
One-fifth of mental health consumers have an additional two visits within the next 30 days, making a total of four visits in the first 45 days (a best practice for full engagement in care). Among LMEs, engagement ranged from a low of 9% (Cumberland) to a high of 37% (Durham).

** Data on service claims for Piedmont are not available for this report.*

Indicator 2: Timely Initiation and Engagement in Service

2.2 Developmental Disability Services

Rationale: Best practice for initiating and engaging consumers in care suggests that an individual receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. April 1 - June 30, 2006 (first service received); N=862 consumers

About three-fifths (59%) of NC residents (all age groups) who receive developmental disability services/supports have two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranges from a low of 38% (Mecklenburg and Foothills) to a high of 86% (Roanoke-Chowan).

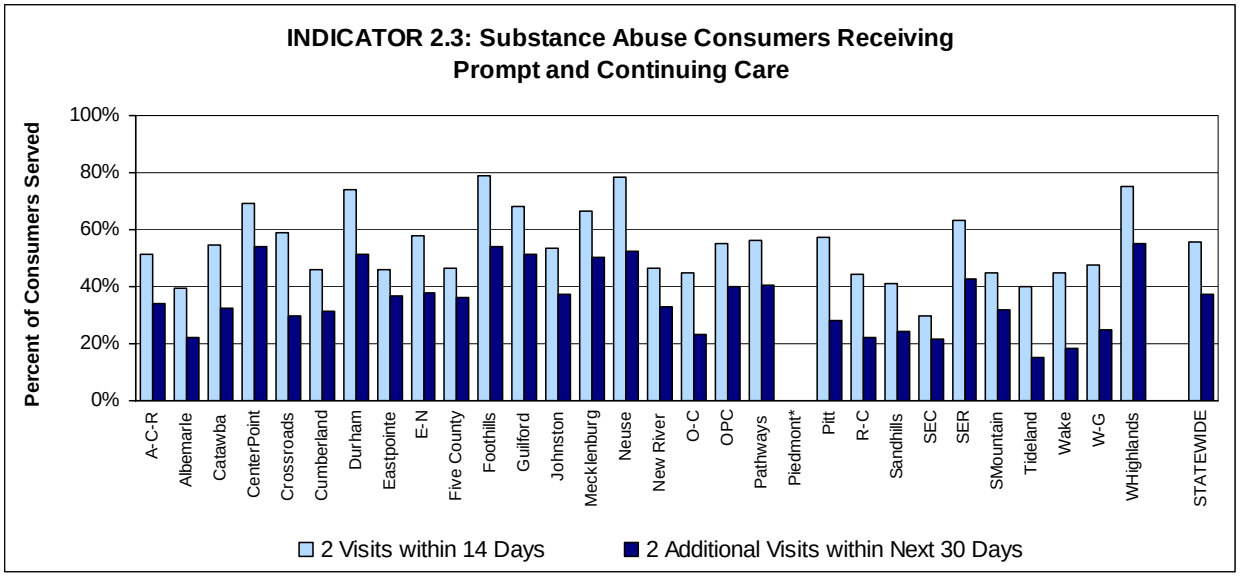
Approximately 45% of developmental disability consumers have an additional two visits within 30 days, making a total of four visits in the first 45 days (a best practice for full engagement in care). Among LMEs, engagement ranged from a low of 20% (Albemarle) to a high of 78% (Wilson-Greene).

** Data on service claims for Piedmont are not available for this report.*

Indicator 2: Timely Initiation and Engagement in Service

2.3 Substance Abuse Services

Rationale: National standards[20] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. April 1 - June 30, 2006 (first service received); N=3,776 consumers

Over half (56%) of NC residents (all age groups) who receive substance abuse services have two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranges from a low of 30% (Southeastern Center) to a high of 79% (Foothills).

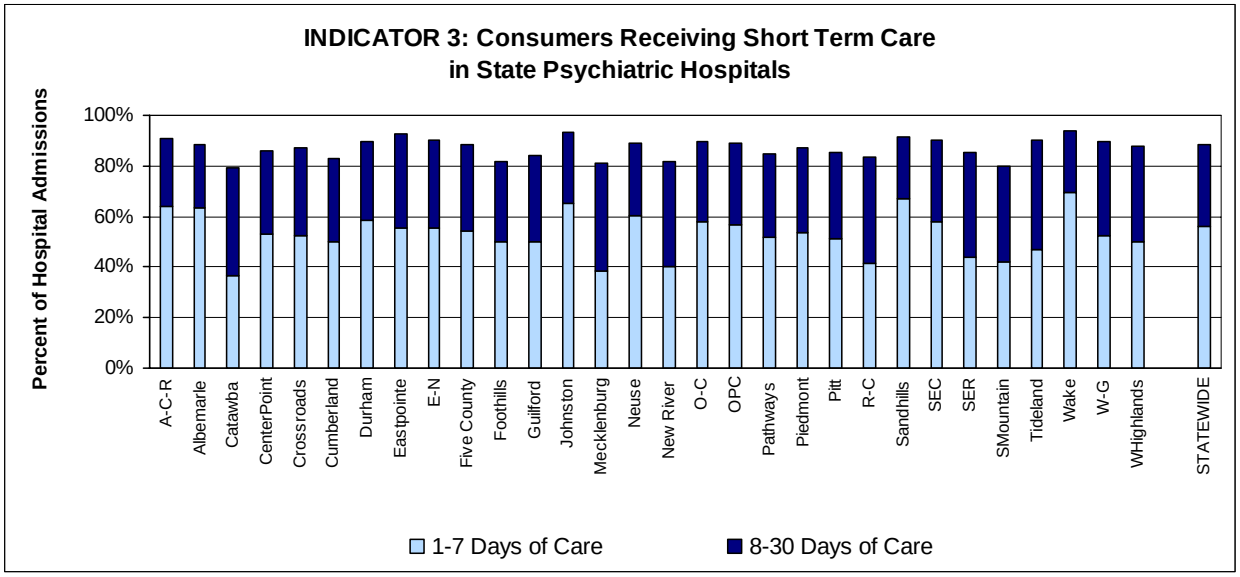
Approximately 37% of substance abuse consumers have an additional two visits within 30 days, making a total of four visits in the first 45 days (the standard for full engagement in care). Among LMEs, engagement ranged from a low of 15% (Tideland) to a high of 55% (Western Highlands).

** Data on service claims for Piedmont are not available for this report.*

[20] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.

Indicator 3: Effective Use of State Psychiatric Hospitals

Rationale: State psychiatric hospitals provide a safety net for the community service system. An adequate community system can and should provide their residents with crisis services and short-term inpatient care close to home. This helps families stay in touch and reserves high-cost state facility beds for consumers with long-term care needs. Reducing the short-term use of state psychiatric hospitals is a goal that also allows more effective and efficient use of funds for community services.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data for discharges during July 1 - December 31, 2006; N=8,896 discharges

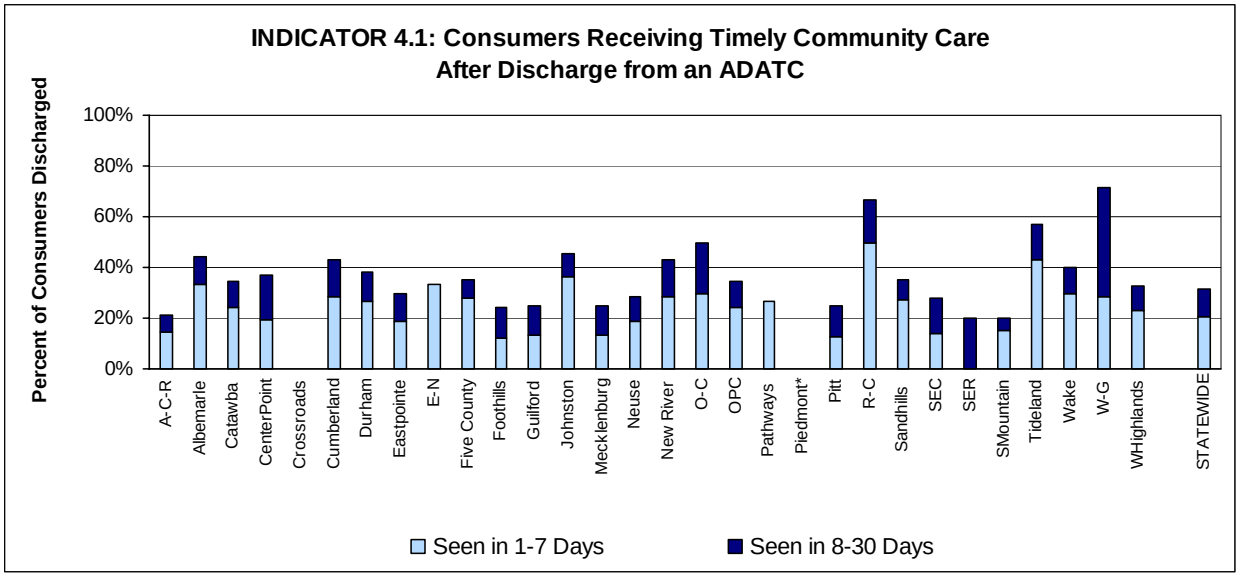
Of the statewide hospital discharges from July through December 2006, over half (56%) were hospitalized for 1-7 days (total number of statewide admissions for 1-7 days was 5,008) and 32% were hospitalized for 8-30 days (total number of statewide admissions for 8-30 days was 2,863). Lengths of stay of 1-7 days varied by LME from a high of 70% (Wake) to a low of 37% (Catawba). Sandhills and Wake had the lowest rates for lengths of stay of 8-30 days (with 24%) while four LMEs had a high of 43% (Catawba, Mecklenburg, Roanoke-Chowan, and Tideland).

Almost 89% of NC's discharges from state psychiatric hospitals in the period of July 1 to December 31, 2006 were for stays of 30 days or less. *As local capacity to provide crisis services increases, the Division expects the number of short-term stays in state psychiatric hospitals to decrease.*

Indicator 4: Timely Follow-Up after Inpatient Care

4.1 ADATCs

Rationale: Living successfully in one's community after discharge from a state-operated facility depends on smooth and timely transition to community services/ supports. Receiving a community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and coordination across levels of care.[21]



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Discharge Data; Medicaid and State Service Claims Data. April 1 - June 30, 2006 (HEARTS discharge dates); N=813 discharges

Statewide approximately 21% of consumers discharged from an ADATC received follow-up care in the community within 7 days. An additional 11% of NC consumers were seen within 8-30 days of discharge.

Among LMEs, the percent of consumers receiving follow-up care within 7 days varied from a low of 0% (Southeastern Regional) to a high of 50% (Roanoke-Chowan). Overall, the percent of consumers receiving follow-up care within 1-30 days varied from a low of 20% (Southeastern Regional and Smoky Mountain) to a high of 72% (Wilson-Greene).

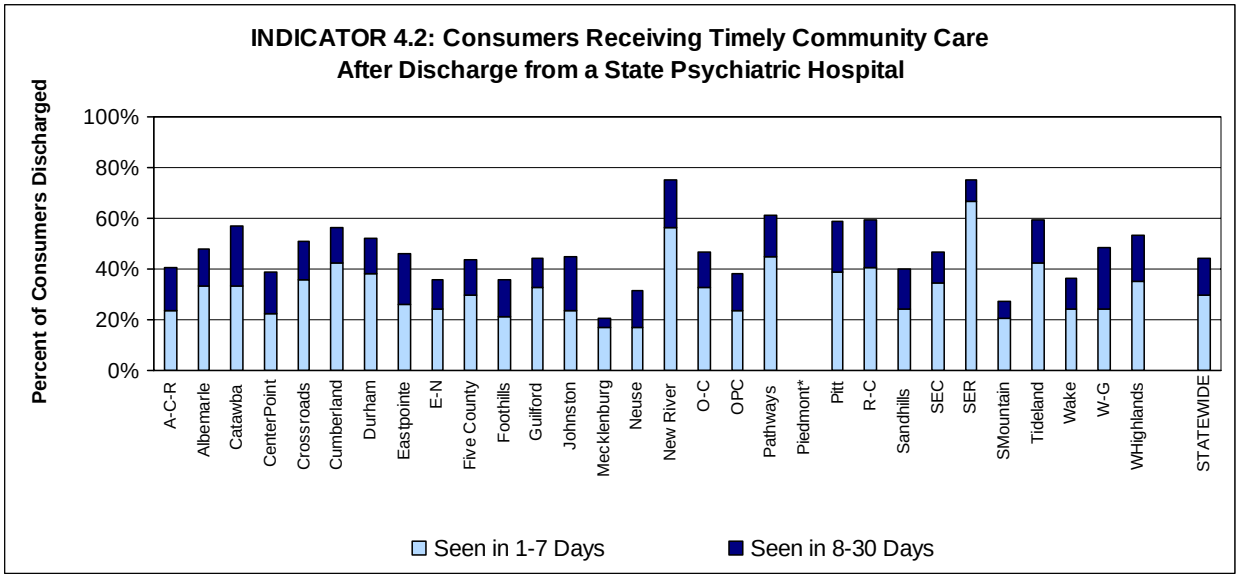
** Data on service claims for Piedmont are not available for this report.*

[21] This is a Health Plan Employer Data and Information Set (HEDIS®) measure.

Indicator 4: Timely Follow-Up after Inpatient Care

4.2 State Psychiatric Hospitals

Rationale: Living successfully in one's community after discharge from a state-operated facility depends on smooth and timely transition to community services/ supports. Receiving a community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and coordination across levels of care.[22]



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Discharge Data; Medicaid and State Service Claims Data. April 1 - June 30, 2006 (HEARTS discharge dates); N=3,884 discharges

Statewide approximately 30% of consumers discharged from state psychiatric hospitals received follow-up care in the community within 7 days. An additional 15% of NC consumers were seen within 8-30 days of discharge.

Among LMEs, the percent of consumers receiving follow-up care within 7 days varied from a low of 17% (Mecklenburg and Neuse) to a high of 67% (Southeastern Regional). Overall, the percent of consumers receiving follow-up care within 1-30 days varied from a low of 21% (Mecklenburg) to a high of 75% (New River and Southeastern Regional).

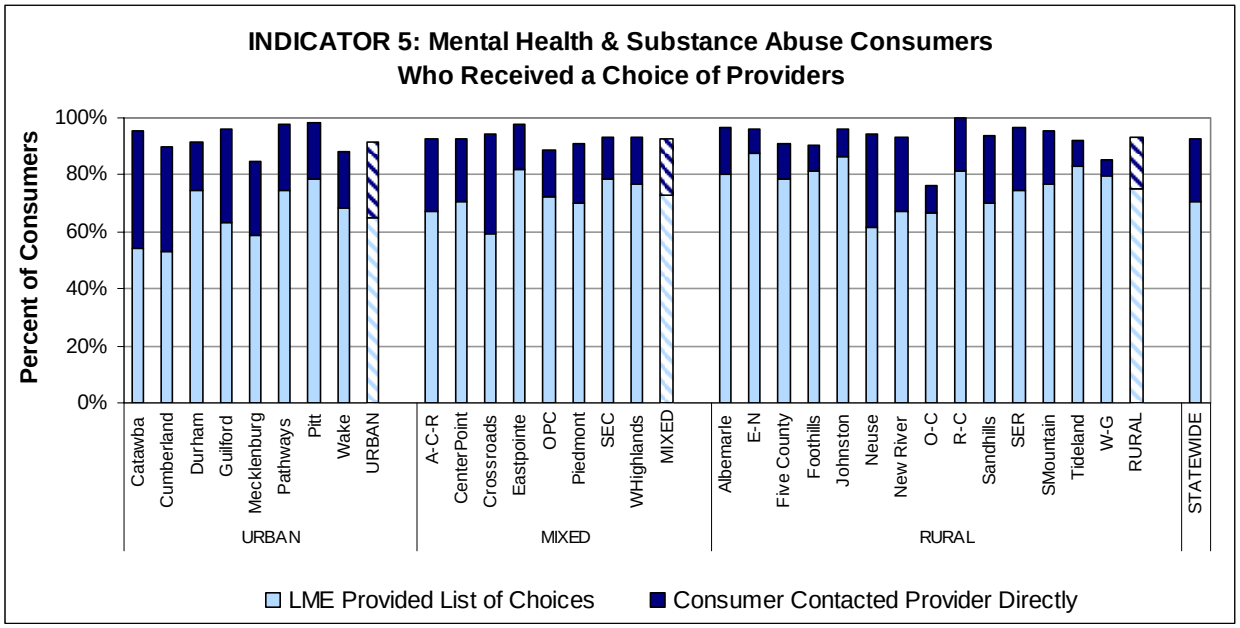
** Data on service claims for Piedmont are not available for this report.*

[22] This is a Health Plan Employer Data and Information Set (HEDIS®) measure.

Service Quality

Indicator 5: Consumer Choice of Service Providers

Rationale: A system that offers consumers an array of providers supports the development of successful practitioner-consumer relationships which, in turn, foster recovery and stability. Consumer choice can also improve the quality of the entire service system, as providers strive to satisfy consumers.



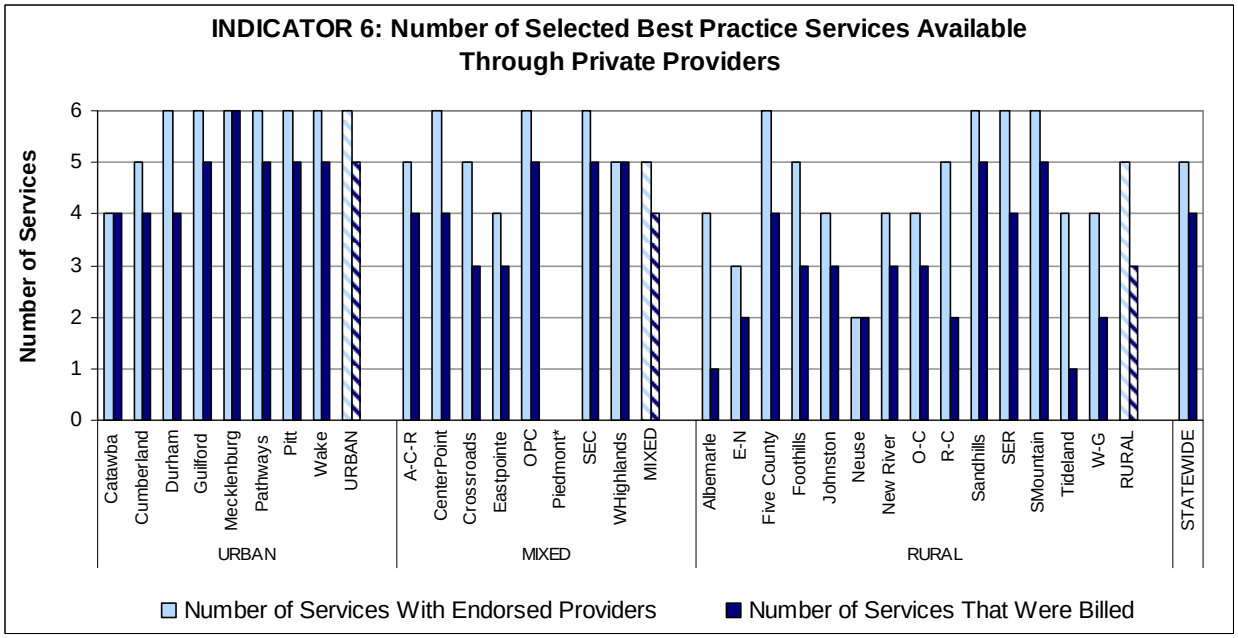
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. October 1 - December 31, 2006; N=10,953

Statewide, over 71% of MH and SA consumers reported receiving options of places to receive services.[23] An additional 22% reported they contacted the provider directly. Among LMEs, the percent of consumers offered a list of options or went directly to a provider varied from a low of 76% (Onslow-Carteret) to a high of 100% (Roanoke-Chowan).

[23] The question in the Initial NC-TOPPS Interview reads: "Did you receive a list or options, verbal or written, of places to receive services?" Response options include "Yes, I received a list," "No, I came here on my own," and "No, I did not receive a list." Appropriate NC-TOPPS questions for DD consumers are currently being developed.

Indicator 6: Use of Evidence-Based Service Models and Best Practices

Rationale: Quality care is care that makes a real difference in an individual's life. Service models and practices that have been tested for effectiveness provide the greatest opportunity for individuals to attain stability in their lives. NC is promoting adoption of evidence-based practices and best practices in community service systems.



SOURCE: Medicaid Provider Endorsement Data and Medicaid Claims Data. March 20 - December 31, 2006; N=2,266 Endorsed Providers

North Carolina has endorsed over 2,200 private provider agencies (other than LMEs) across the state to offer six services that are based on best practice models:

- Multi-systemic therapy (MST)**
- Assertive community treatment team (ACTT)**
- Community support/community support team (CS/CST)
- Intensive in-home (IIH)
- Substance abuse intensive outpatient program (SAIOP)
- Substance abuse comprehensive outpatient treatment (SACOT).

All six services are endorsed in thirteen LMEs, although only Mecklenburg has agencies that are currently providing all of them. Nine LMEs have agencies currently providing five of these services and seven LMEs have agencies providing four of these services.

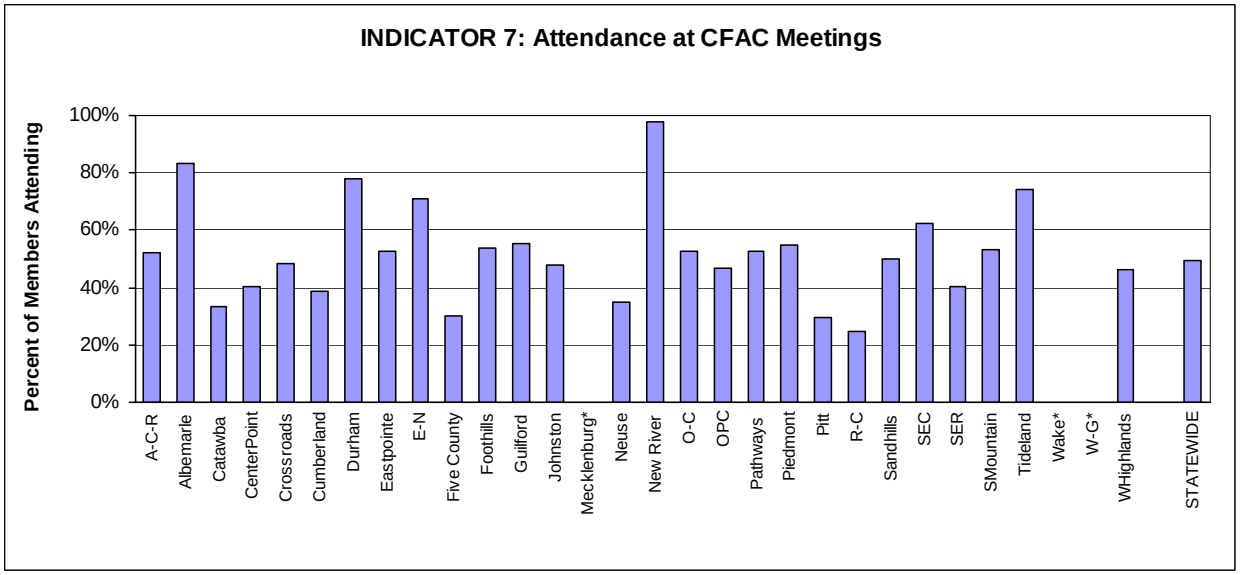
** Data on service claims for Piedmont are not available for this report.*

*** Multi-systemic therapy (MST) and assertive community treatment team (ACTT) are evidence-based practices.*

System Management

Indicator 7: Involvement of Consumers and Family Members in the Local System

Rationale: The vibrancy of the local Consumer and Family Advisory Committees (CFACs) provides an indication of the responsiveness of the local system and its effectiveness in meeting the needs of residents and consumers. An engaged CFAC membership, with balanced representation across disabilities, is necessary for the LME to hear and respond to the needs of its community.



SOURCE: Local CFAC meeting minutes. October 1 - December 31, 2006

Local Consumer and Family Advisory Committees (CFACs) are composed of consumers and family members representing each of the MH/DD/SA disabilities. CFACs in 16 LMEs met monthly during the quarter. CFACs in 11 LMEs met two times during the quarter. Albemarle and Smoky Mountain met once. Statewide, the expected membership ranges from 9 in Guilford to 30 in OPC. Across the state, an average of 50% of expected members attended scheduled meetings.[24] Roanoke-Chowan had the lowest average of expected attendance (25% of 12 potential members) and New River had the highest (98% of 15 potential members).

** Edgecombe-Nash and Wilson-Greene share one CFAC and are reported under Edgecombe-Nash. Mecklenburg and Wake have not set an expected number of members. Mecklenburg averaged 14 members attending and Wake averaged 11 members attending.*

[24] Numbers in attendance include only appointed members.

Indicator 8: Effective Management of Service Funds

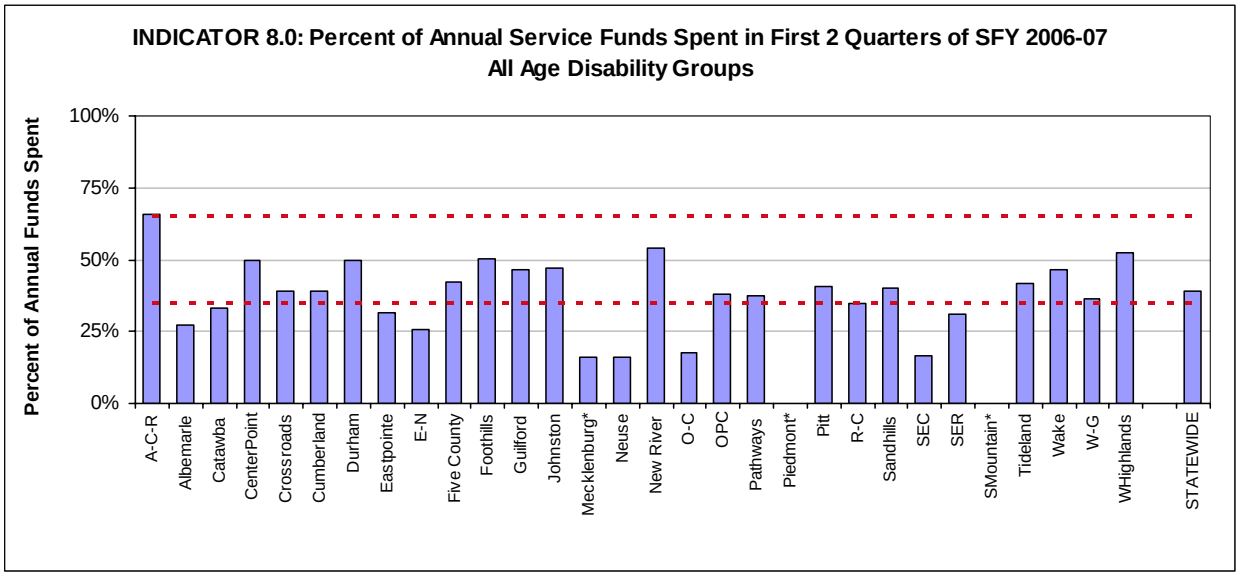
8.0 All Disability Groups

Rationale: Appropriating using limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

LME use of state and federal (non-Medicaid) funds can be affected by several factors, including[25]:

- the availability and use of local funds
- the proportion of the local population receiving Medicaid services
- local claims submission practices

Future reports will provide cumulative information on funds spent to-date in the fiscal year.



SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1 - December 31, 2006;
Total Budgeted UCR Funds=$282,744,204

Expenditures are expected to be between 35% and 65% at the end of the second quarter, as indicated by the dotted red lines. Across all disabilities statewide, LMEs spent approximately 39% of their LME-managed service funds during the first and second quarters of SFY 2006-07 (October-December 2006).[26] Expenditures vary from a low of 16% (Mecklenburg, Southeastern Center and Neuse) to a high of 66% (Alamance-Caswell-Rockingham). Funds expended vary much more by age-disability group.

** Service claims data for Piedmont and Smoky Mountain are not available for this report. Mecklenburg's numbers may be underreported due to problems in their information management system.*

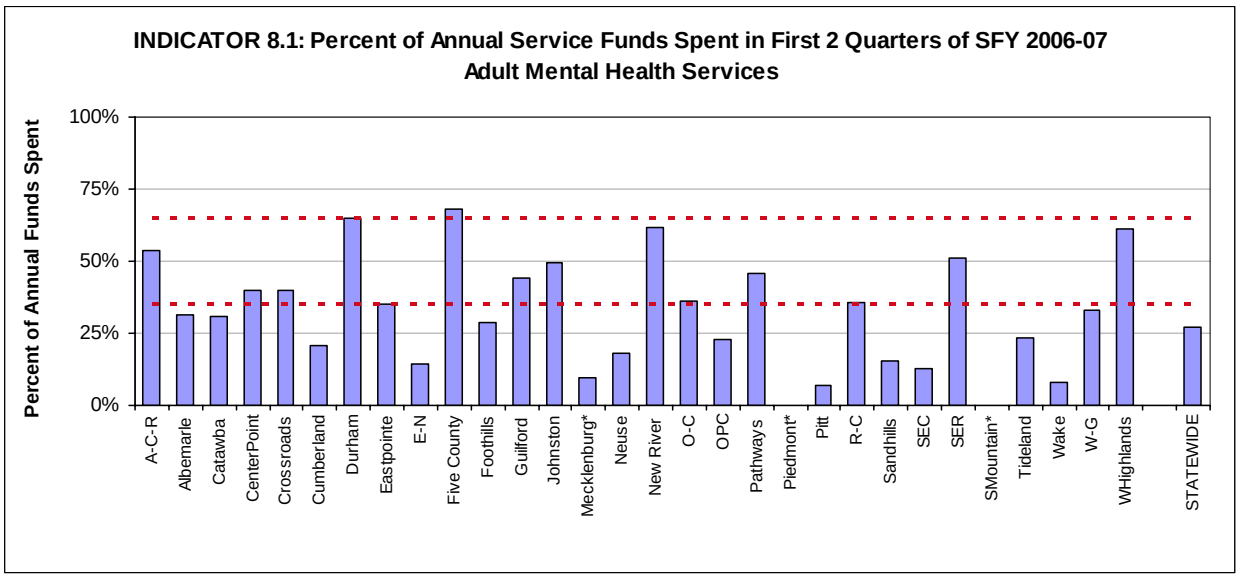
[25] In SFY 2006-07 LMEs are allowed to shift up to 15% of State-allocated funds between age-disability groups.

[26] The numbers exclude funds allocated or processed outside of IPRS. Budgets have been updated to reflect change in allocations since September 2006.

Indicator 8: Effective Management of Service Funds
8.1 Adult Mental Health Services

Rationale: Appropriating using limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

Future reports will provide cumulative information on funds spent to-date in the fiscal year.



SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1 - December 31, 2006;
Total Budgeted UCR Funds= $79,053,743

Expenditures are expected to be between 35% and 65% at the end of the second quarter, as indicated by the dotted red lines. In SFY 2006-07, 27% of LME-managed funds for adult mental health services were expended in the first and second quarters of this fiscal year.[27] The percent of funds spent varied across LMEs from a low of 7% (Pitt) to a high of 68% (Five County).

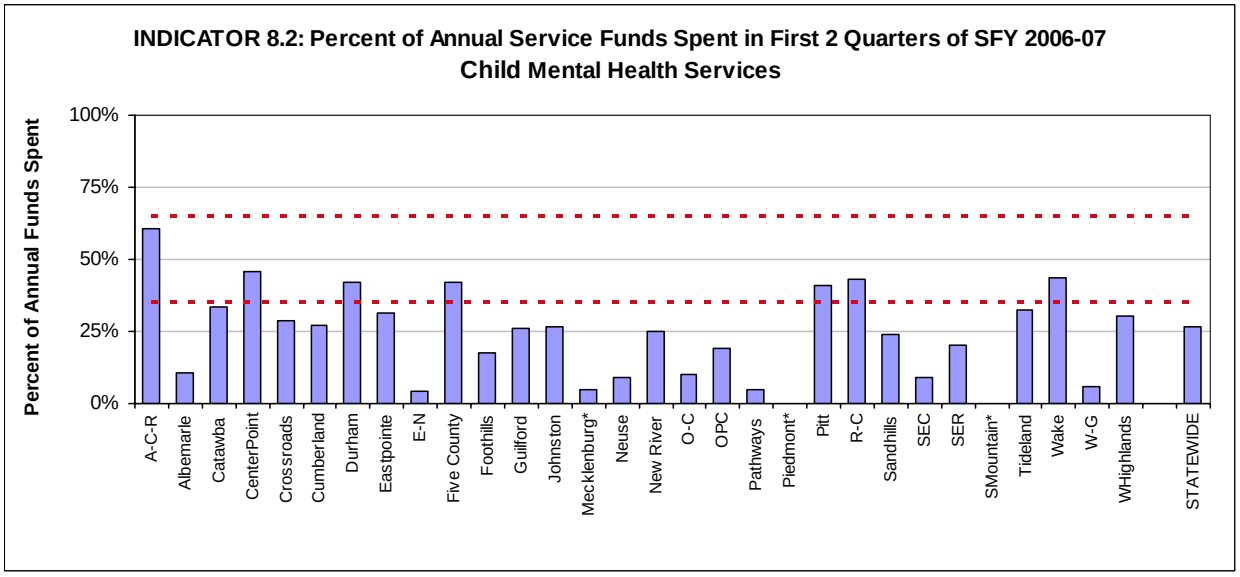
** Service claims data for Piedmont and Smoky Mountain are not available for this report. Mecklenburg's numbers may be underreported due to problems in their information management system.*

[27] The numbers exclude funds allocated or processed outside of IPRS. Budgets have been updated to reflect change in allocations since September 2006.

Indicator 8: Effective Management of Service Funds
8.2 Child Mental Health Services

Rationale: Appropriating using limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

Future reports will provide cumulative information on funds spent to-date in the fiscal year.



SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1 - December 31, 2006;
Total Budgeted UCR Funds= $40,875,920

Expenditures are expected to be between 35% and 65% at the end of the second quarter, as indicated by the dotted red lines. Approximately 27% of SFY 2006-07 LME-managed funds for child mental health services were expended in the first and second quarters of this fiscal year.[28] The percent of funds spent varied across LMEs from a low of 4% (Edgecombe-Nash) to a high of 60% (Alamance-Caswell-Rockingham).

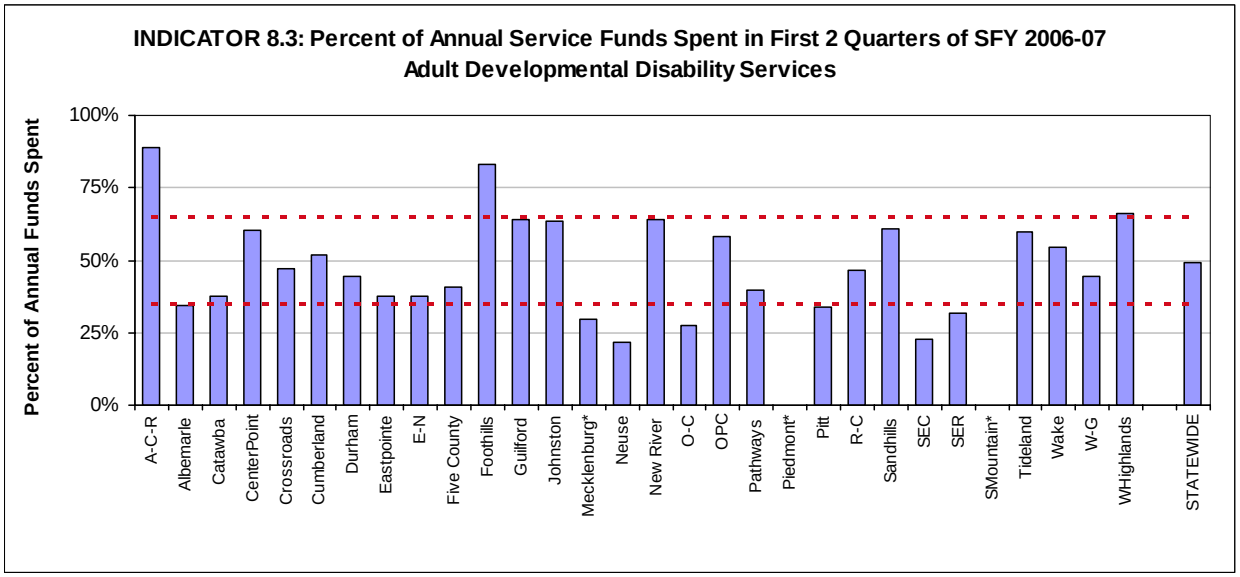
** Service claims data for Piedmont and Smoky Mountain are not available for this report. Mecklenburg's numbers may be underreported due to problems in their information management system.*

[28] The numbers exclude funds allocated or processed outside of IPRS. Budgets have been updated to reflect change in allocations since September 2006.

Indicator 8: Effective Management of Service Funds
8.3 Adult Developmental Disability Services

Rationale: Appropriating using limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

Future reports will provide cumulative information on funds spent to-date in the fiscal year.



SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1 - December 31, 2006;
Total Budgeted UCR Funds= $125,515,294

Expenditures are expected to be between 35% and 65% at the end of the second quarter, as indicated by the dotted red lines. Approximately 49% of SFY 2006-07 LME-managed funds for adult developmental disability services were expended in the first and second quarters of this fiscal year.[29] The percent of funds spent varied across LMEs from a low of 22% (Neuse) to a high of 89% (Alamance-Caswell-Rockingham).

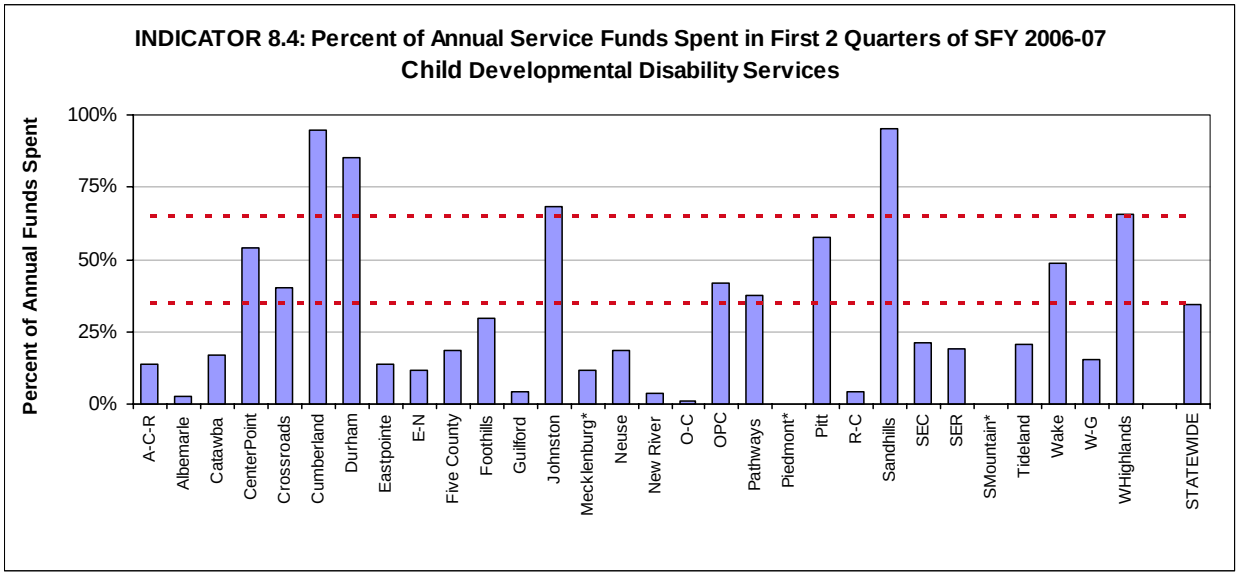
** Service claims data for Piedmont and Smoky Mountain are not available for this report. Mecklenburg's numbers may be underreported due to problems in their information management system.*

[29] The numbers exclude funds allocated or processed outside of the Unit Cost Reimbursement (UCR) system. Budgets have been updated to reflect change in allocations since September 2006.

Indicator 8: Effective Management of Service Funds
8.4 Child Developmental Disability Services

Rationale: Appropriating using limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

Future reports will provide cumulative information on funds spent to-date in the fiscal year.



SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1 - December 31, 2006;
Total Budgeted UCR Funds= $17,518,822

Expenditures are expected to be between 35% and 65% at the end of the second quarter, as indicated by the dotted red lines. Approximately 34% of SFY 2006-07 LME-managed funds for child developmental disability services were expended in the first and second quarters of this fiscal year.[30] The percent of funds spent varied across LMEs from a low of 1% (Onslow-Carteret) to a high of 95% (Sandhills).

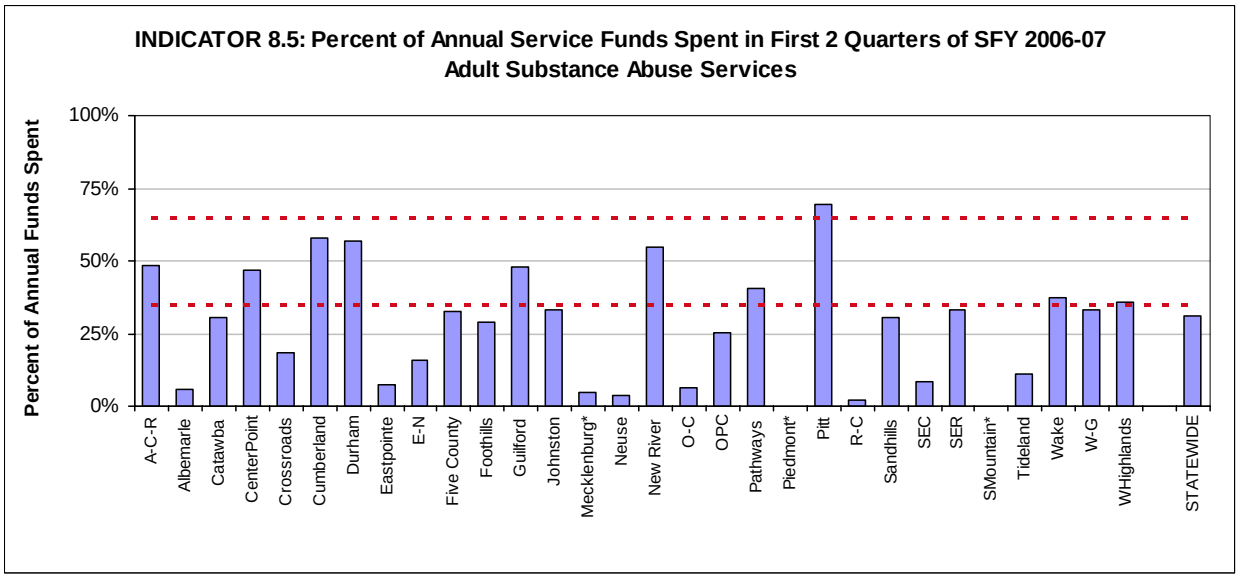
** Service claims data for Piedmont and Smoky Mountain are not available for this report. Mecklenburg's numbers may be underreported due to problems in their information management system.*

[30] The numbers exclude funds allocated or processed outside of IPRS. Budgets have been updated to reflect change in allocations since September 2006.

Indicator 8: Effective Management of Service Funds
8.5 Adult Substance Abuse Services

Rationale: Appropriating using limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

Future reports will provide cumulative information on funds spent to-date in the fiscal year.



SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1 - December 31, 2006;
Total Budgeted UCR Funds= $33,669,590

Expenditures are expected to be between 35% and 65% at the end of the second quarter, as indicated by the dotted red lines. Approximately 31% of SFY 2006-07 LME-managed funds for adult substance abuse services were expended in the first and second quarters of this fiscal year.[31] The percent of funds spent varied across LMEs from a low of 2% (Roanoke-Chowan) to a high of 70% (Pitt).

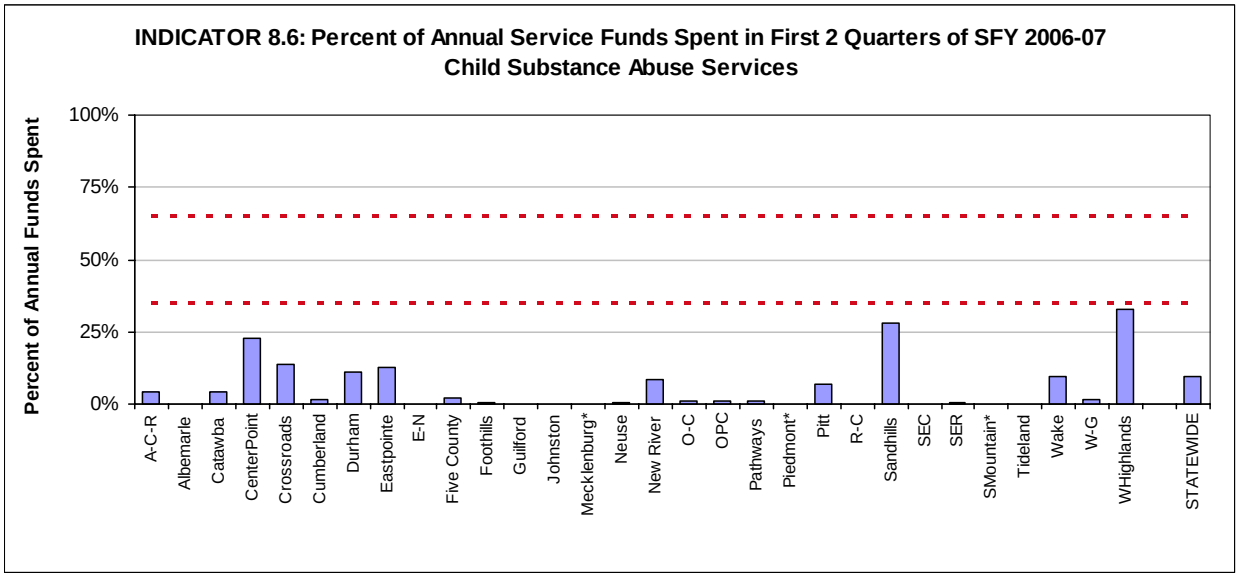
** Service claims data for Piedmont and Smoky Mountain are not available for this report. Mecklenburg's numbers may be underreported due to problems in their information management system.*

[31] The numbers exclude funds allocated or processed outside of IPRS. Budgets have been updated to reflect change in allocations since September 2006.

Indicator 8: Effective Management of Service Funds
8.6 Child Substance Abuse Services

Rationale: Appropriating using limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

Future reports will provide cumulative information on funds spent to-date in the fiscal year.



SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1 - December 31, 2006;
Total Budgeted Funds= $7,315,186

Expenditures are expected to be between 35% and 65% at the end of the second quarter, as indicated by the dotted red lines. Approximately 10% of SFY 2006-07 LME-managed funds for child substance abuse services were expended in the first and second quarters of this fiscal year, by far the lowest expenditures for any age-disability group.[32] Nine of the LMEs spent no State funds on children with substance abuse service needs. Western Highlands, with the greatest expenditures, spent 33% of their funds.

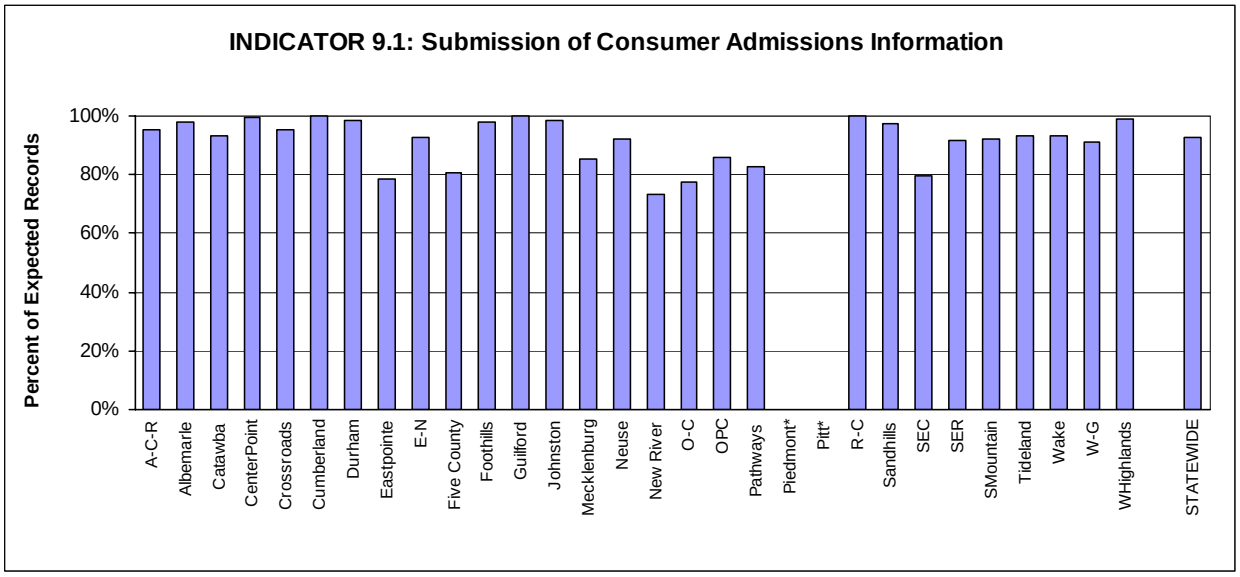
** Service claims data for Piedmont and Smoky Mountain are not available for this report. Mecklenburg's numbers may be underreported due to problems in their information management system.*

[32] The numbers exclude funds allocated or processed outside of IPRS. Budgets have been updated to reflect change in allocations since September 2006.

Indicator 9: Effective Management of Information

9.1 Consumer Admissions

Rationale: Efficient flow of information is vital for effective decision making and oversight of a complex service system. Timely submission of consumer information is a gauge of the management and coordination capacity of the local system and the technological resources available to support it.



SOURCE: Consumer Data Warehouse Admissions Data (for admissions July – September 2006); Medicaid and State Service Claims Data. January 1 - September 30, 2006; N=27,162 records received

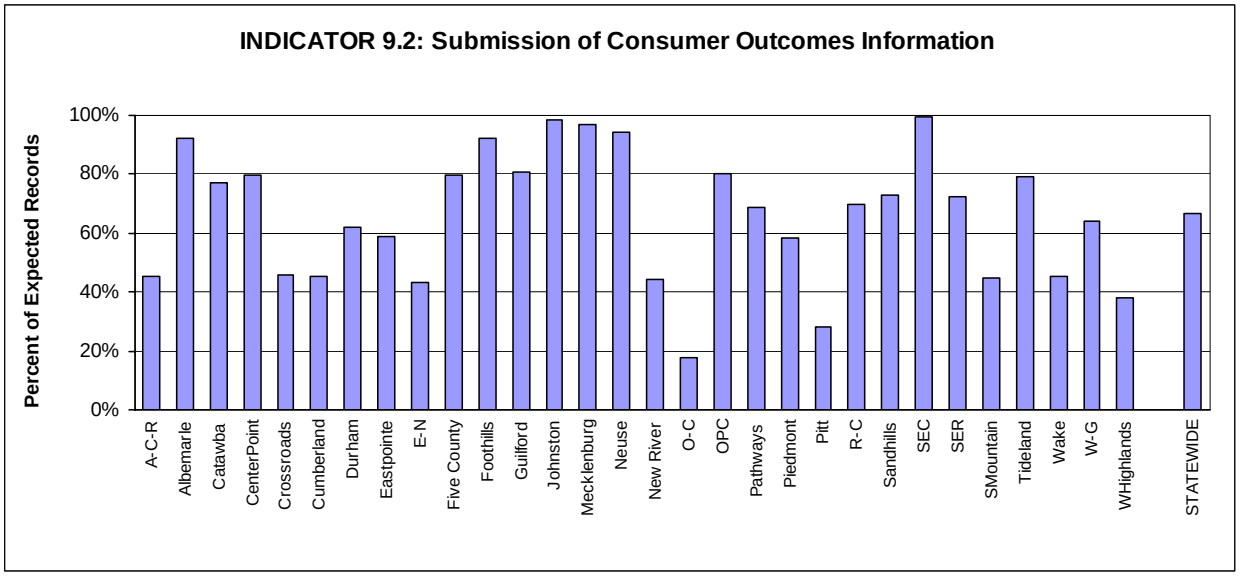
Statewide, the Division received identification and demographic information[33] on 93% of new consumers within 30 days of their admission to an LME. Submissions varied among LMEs from a low of 73% (New River) to a high of 100% by three LMEs (Cumberland, Guilford, and Roanoke-Chowan).

** Admissions data for Pitt are reported under Neuse. Piedmont data are not are not available for this report.*

[33] Consumer Data Warehouse Records Type 10 and 11.

Indicator 9: Effective Management of Information
9.2 Consumer Outcomes

Rationale: Efficient flow of information is vital for effective decision making and oversight of a complex service system. Timely submission of consumer information is a gauge of the management and coordination capacity of the local system and the technological resources available to support it.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data (for Initial Interviews April – June 2006). Updates received April 1 - December 31, 2006; N=15,802 expected updates

Statewide, NC-TOPPS Update Interviews (due after 90 days of service) were submitted for 67% of MH/SA consumers who had an Initial Interview between April and June 2006.[34] The percent of expected Update Interviews submitted varied among LMEs from a low of 18% (Onslow-Carteret) to a high of 100% (Southeastern Center).

[34] Statewide, the Division received about two-thirds of the expected Initial NC-TOPPS Interviews for this period. This represents an improvement over earlier quarters of SFY 2005-06. Each LME's performance on submission of Initial Interviews is similar to their performance on Update Interviews, shown above.

Indicators in Development

Indicators in Development

Timely Access to Services

When an individual makes a request for service, quick response with the appropriate level of care is a gauge of the system's service capacity and coordination efforts. National standards for access include providing care in less than two hours of request in emergent situations, within 48 hours in urgent situations, and within 7 days in routine situations.[35]

In January 2006 LMEs began submitting information to the Division on all persons requesting services. This data will be matched to service claims data to determine the percent of persons who received necessary emergent services within 2 hours of request, urgent services within 48 hours, and routine services within 7 days.

In addition, in July 2006, the Division began asking consumers whether or not their first service was in a timeframe that met their needs, as part of the Initial NC-TOPPS Interview.

Future reports will provide the results of these new indicators.

Person-Centered Service Planning and Delivery

Consumer recovery and stability hinge on designing community services to meet the needs of each individual. A timely, comprehensive service plan developed in collaboration with each consumer and the significant people in his or her life is crucial to designing and delivering individualized services. Increasing the number of consumers with person-center plans is a means to this end.

The LMEs are responsible for reviewing the Person-Centered Plans (PCPs) of all state funded consumers and 15% of Medicaid consumers for completeness and appropriateness and providing technical assistance to providers as needed. The indicator in future reports will show the number of PCPs reviewed by each LME, the number of those that needed revision, and the number for which the LME provided technical assistance.

Effective Oversight of Service Quality

Local oversight of community services is essential for risk management and continuous improvement of the quality of care. LMEs' assessment of their providers' strengths and areas of need can target technical assistance activities effectively. Increasing oversight to those providers with the greatest need for assistance improves the quality of the choices available to consumers.

Each LME is responsible for assessing its confidence in the quality of all providers operating in its catchment area and providing technical assistance and oversight to providers, as needed. The indicator to be included in future reports will show the percent of providers that the LME rated in the "low confidence" category and the percent of that group that the LME monitored or provided with technical assistance during the quarter.

[35] Health Plan Employer Data and Information Set (HEDIS®) measures.

Implementation of Management Functions

The LMEs' management of MH/DD/SA services in their catchment areas involves the following eight functions:

- Governance and Administration
- Business Management and Human Resources
- Provider Relations
- Customer Service and Consumer Affairs
- Service Management
- Quality Management
- Claims Adjudication
- Access, Screening, Triage and Referral

In 2006 SL 2006-0142 (House Bill 2077) amended G.S>122-C-112.1(a)(33) to require the Secretary to:

> "Develop and implement critical performance indicators to be used to hold LMEs accountable for managing the mental health, developmental disabilities, and substance abuse services system. The performance system indicators shall be implemented no later than July 1, 2007."

The Division is currently working with a consultant to develop critical indicators for evaluating each function through data submitted by the LMEs and on-site visits. Data on these indicators will be published in a separate report beginning in SFY 2007-08.

The MH/DD/SAS Community Systems Progress Indicators Report and the Report Appendix are published four times a year. Both are available on the Division's website: http://www.dhhs.state.nc.us/mhddsas/statspublications/index.htm.

Questions and feedback should be directed to:
NC DMH/DD/SAS Quality Management Team
ContactDMHQuality@ncmail.net
(919/733-0696)